

INFLUENZA VACCINE CONSENT FORM

Standard Quadrivalent Vaccine

High Dose Influenza Vaccine

Patient's Name _____/_____/_____
Date of Birth Age Gender

Home Address (No P.O. Box) City / State Email (_____) Phone

Please answer the following:

Is this your first flu shot? Yes / No
Have you ever had a serious reaction to a flu shot? Yes / No
Are you sick with a fever today? Yes / No
Are you allergic to eggs or Thimerosal (preservative found
in contact lens solution), any vaccine ingredient or latex? Yes / No
Have you ever had a neurological disease or Guillian-Barre Syndrome? Yes / No
Are you pregnant or a nursing mother? Yes / No

Primary Insurance Plan:

Medicare B Aetna Anthem Cigna Connecticare UHC Oxford United Healthcare Self Pay

Secondary Insurance Plan, if any:

Medicare B Aetna Anthem Cigna Connecticare UHC Oxford United Healthcare

X _____ Date: _____

Signature of recipient (or parent or guardian)

Influenza injection & billing consent:

I have read or had explained to me, the information sheet about influenza vaccination, dated 08/07/2015. I have had a chance to ask questions which were answered to my satisfaction and understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me or the person named above for whom I am authorized to make this request. I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim. **I understand that if my insurance rejects payment for this vaccination the Trumbull Health Department will bill me and will agree to pay the fee.**

HIPAA: Reviewed copy made available on site ☐ Received copy per my request ☐

FOR NURSES ONLY:

Vaccine Site: Left Deltoid Right Deltoid **Dosage:** 0.5cc **Manufacturer:** Sanofi-Pasteur **Lot Number:** _____
CIRCLE ONE

Nurse Signature Date